STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155632	A. BUILDING 00 B. WING	07/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LODGE OF THE WABASH	723 E RAMSEY RD VINCENNES, IN47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00092333. Complaint IN00092333 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Unrelated deficiency is cited. Survey dates: July 11 and 12, 2011 Facility number: 001138 Provider number: 155632 AIM number: 200157070 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 52 Residential: 12 Total: 64 Census payor type: Medicare: 5 Medicaid: 46 Other: 13 Total: 64 Sample: 4	F0000	F0000Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the law.Submissions of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission against interest of the Facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegations by the survey agency.This Plan of Correction shall constitute this facility's credible allegation of compliance on or before August 11, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/14/11 by Suzanne Williams, RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident remained free from mistreatment and abuse, in that she was secluded on the floor behind a nurses' station, for 1 of 4 residents sampled for abuse, in a sample of 4. Resident A Findings include: 1. On 7/11/11 at 9:10 A.M., the Director of Nursing [DON] provided a "Fax/Incident Report" to the Indiana State Department of Health, dated 6/16/11. The report included, "An incident was reported to the Director of Nursing Services on 05/13/2011 at approximately 2:00 P.M. by [QMA # 1]. She reported that on the evening of May 9th, 2001 [sic], at approximately 10:30 P.M., [LPN # 1] instructed [CNA # 3] to assist her to	F0223	F223All staff training on the facility abuse prohibition and reporting policy was conducted on May 23 and July 25, 2011.LPN #1 was immediately suspended pending investigation and terminated for failure to follow established facility policy. LPN #3 and all other staff present were counseled regarding facility policy and reporting requirements.There was no evidence of harm to Resident A.Facility policies and protocols have been reviewed and are consistent with current accepted standards of practice.The facility did conduct an immediate and timely appropriate action was taken including immediate suspension and termination of LPN #1.In accordance with facility policy and the law, the NHA or designee will report allegations within 24 hours of incident as appropriate.The NHA will randomly question staff during daily rounds twice per	07/31/2011

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	remove [Resident A] from her wheelchair and place her on the floor behind the central nurses station. The area being described is open for all residents and staff to view. [QMA # 1] reports to DON that the first request from [LPN # 1] to [CNA # 3] was ignored. Upon second request from [LPN # 1] to [CNA # 3] at that time [CNA # 3] did assist her nurse in laying said resident on the carpeted floor behind the nurses work station. The DON phoned [CNA # 3] regarding this occurrence, at that time she confirmed that the incident actually did occur. She states exactly the same facts previously reported by [QMA # 1] and adds she did not feel good about the situation, however it only lasted for approximately 20-30 minutes, and then she placed said resident in her bed for slumber...." On 7/11/11 at 10:35 A.M., during interview with LPN # 2, she indicated she was working evening shift on 5/9/11. LPN # 2 indicated Resident A "had dementia, and was in and out of bed." LPN # 2 indicated the evening staff had put Resident A in a wheelchair and had wheeled her to the nursing station at approximately 10:30 P.M. LPN # 2 indicated LPN # 1 was the oncoming night shift nurse, and said "I'm not going to do this all night," and had her CNA put Resident A on the floor. LPN # 2		week for six weeks and weekly for four months regarding staff knowledge of misconduct definitions and reporting requirements. A recap of the facility safety policy will be provide to staff at month meetings for the following six months.The NHA will monitor for compliance and report any negative finding to the Quality Assurance committee.	

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	indicated she told LPN # 1, "You can't do that." LPN # 2 indicated her shift was over, and as her and the other evening shift nurse were walking out, they discussed that LPN # 1 "shouldn't have done that." LPN # 2 indicated, "We should have said something." On 7/11/11 at 12:05 P.M., during interview with QMA # 1, she indicated she was working evening shift on 5/9/11. She indicated, "[Resident A] sometimes won't lay still in bed. We sat her at the nurses desk. The other shift came in. I heard [LPN # 1] tell an aide 'Help me.' They were picking [Resident A] up and laying her on the floor. She was just sitting on the floor, and then laid over. I looked at [LPN # 3] who was my supervisor. Then I said, 'I'm out of here.'" QMA # 1 indicated this happened at approximately 10:30 P.M., at the end of her shift. QMA # 1 indicated she reported the incident to the DON 4 days later, because she "thought I would explode." QMA # 1 indicated the incident made her sick to her stomach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday afternoon, and was tearful. She said something happened the previous Monday at approximately 10:25-10:30 P.M. She			

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	said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'Come here and help me. We are just going to lay her down on the floor.' [CNA # 3] helped [LPN # 1] lay her on the floor." The DON indicated she immediately inserviced staff on abuse, gave written warnings, and terminated LPN # 1 after an investigation. On 7/11/11 at 1:20 P.M., during interview with LPN # 3, she indicated she was working evening shift on 5/9/11. She indicated her shift was almost over, and "[Resident A] had been up and down." She indicated Resident A was sitting in a wheelchair at the nurses desk, and LPN # 1 said, "Let's put her down on the floor." LPN # 3 indicated CNA # 3 at first just ignored her, but then LPN # 1 asked again, and she saw them put Resident A on the floor. LPN # 3 indicated someone got a mat and put it against the desk so Resident A could lean against the mat. LPN # 3 indicated, "Then [Resident A] just leaned down to the floor. She wasn't on a mat or anything. I don't think she even had a pillow. We were just shocked." LPN # 3 indicated her and LPN # 2 then left, and discussed the incident, and said, "This ain't right." LPN # 3 indicated that LPN # 1 was the 11-7 charge nurse, and they didn't want to question her. LPN # 3 indicated, "She was totally wrong, and we			

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	were wrong. We should have told someone." On 7/11/11 at 9:30 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and Parkinson's disease. An admission Minimum Data Set [MDS] assessment, dated 3/14/11, indicated the resident scored a 5 out of 15 on cognitive status, with 15 indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of two+ staff for transfer and toilet use, and did not ambulate. A test for "Balance During Transitions and Walking" indicated the resident was "not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, turning around, moving on and off of the toilet, and surface-to-surface transfer. The MDS assessment indicated Resident A had fallen since admission and received one injury. 2. On 7/11/11 at 10:40 A.M., the Director of Nursing provided the current facility policy on "Resident Safety Abuse Statement," revised 1/11. The policy included: "Purpose: It is the policy of our facility to maintain a work and living			

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	environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion and misappropriation of property...Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being...Involuntary seclusion is defined as separation of a resident from other residents or from his/her room...." This Federal tag relates to Complaint IN00092333. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure allegations of abuse were reported timely to the Administrator and State agency, in that staff secluded Resident A and staff did not	F0225	F225The facility does not employ individuals who have been found guilty of any form of mistreatment, nor does the facility employ any persons with negative findings on the nurse aide	07/31/2011

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	report the incident to the Administrator for 4 days, and the incident was not reported to the State agency for over 1 month, for 1 of 4 residents sampled for allegations of abuse, in a sample of 4. Resident A Findings include: 1. On 7/11/11 at 9:10 A.M., the Director of Nursing [DON] provided a "Fax/Incident Report" to the Indiana State Department of Health, dated 6/16/11. The report included, "An incident was reported to the Director of Nursing Services on 05/13/2011 at approximately 2:00 P.M. by [QMA # 1]. She reported that on the evening of May 9th, 2001 [sic], at approximately 10:30 P.M., [LPN # 1] instructed [CNA # 3] to assist her to remove [Resident A] from her wheelchair and place her on the floor behind the central nurses station. The area being described is open for all residents and staff to view. [QMA # 1] reports to DON that the first request from [LPN # 1] to [CNA # 3] was ignored. Upon second request from [LPN # 1] to [CNA # 3] at that time [CNA # 3] did assist her nurse in laying said resident on the carpeted floor behind the nurses work station. The DON phoned [CNA # 3] regarding this occurrence, at that time she confirmed that the incident actually did occur. She		registry.All staff training on the facilty abuse prohibition and reporting policy was conducted May 23 and July 25, 2011.LPN #1 was immediately suspended pending investigation and terminated for failure to follow established facility policy. LPN #3 and all other staff present were counseled regarding facility policy and reporting requirements.There was no evident harm to Resident A. After subsequent review, the facility submitted a report summary to the State Department of Health. Facility policies and protocols have been reviewed and are consistent with current accepted standards of practice. The facility did conduct an immediate investigation and timely, appropriated action was taken including the immediate suspension and termination of LPN #1.In accordance with facility policy and law, the NHA or designee will report allegations within 24 hours of the incident as appropriate.The NHA will randomly question staff during daily rounds twice per week for six weeks and weekly for four month regarding staff knowledge of misconduct definitions and reporting requirements. A recap of the facility safety policy will be provided to staff at monthly meetings for the following six months.The NHA will monitor for compliance and report any negative findings to the Quality Assurance committee.	

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	states exactly the same facts previously reported by [QMA # 1] and adds she did not feel good about the situation, however it only lasted for approximately 20-30 minutes, and then she placed said resident in her bed for slumber..As I am aware this reporting is thirty days past the actual incident of occurrence, through the QA [quality assurance] process the IDT [interdisciplinary team] felt it important to report this incident to prevent possible occurrence in an alternate long term care facility." On 7/11/11 at 10:35 A.M., during interview with LPN # 2, she indicated she was working evening shift on 5/9/11. LPN # 2 indicated Resident A "had dementia, and was in and out of bed." LPN # 2 indicated the evening staff had put Resident A in a wheelchair and had wheeled her to the nursing station at approximately 10:30 P.M. LPN # 2 indicated LPN # 1 was the oncoming night shift nurse, and said "I'm not going to do this all night," and had her CNA put Resident A on the floor. LPN # 2 indicated she told LPN # 1, "You can't do that." LPN # 2 indicated her shift was over, and as her and the other evening shift nurse were walking out, they discussed that LPN # 1 "shouldn't have done that." LPN # 2 indicated, "We should have said something."			

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	On 7/11/11 at 12:05 P.M., during interview with QMA # 1, she indicated she was working evening shift on 5/9/11. She indicated, "[Resident A] sometimes won't lay still in bed. We sat her at the nurses desk. The other shift came in. I heard [LPN # 1] tell an aide 'Help me.' They were picking [Resident A] up and laying her on the floor. She was just sitting on the floor, and then laid over. I looked at [LPN # 3] who was my supervisor. Then I said, 'I'm out of here.'" QMA # 1 indicated this happened at approximately 10:30 P.M., at the end of her shift. QMA # 1 indicated she reported the incident to the DON 4 days later, because she "thought she would explode." QMA # 1 indicated the incident made her sick to her stomach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday afternoon, and was tearful. She said something happened the previous Monday at approximately 10:25-10:30 P.M. She said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'come here and help me. We are just going to lay her down on the floor.' [CNA # 3] helped [LPN # 1] lay her on the floor." The DON indicated she immediately inserviced staff on abuse,			

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	gave written warnings, and terminated LPN # 1 after an investigation. On 7/11/11 at 1:20 P.M., during interview with LPN # 3, she indicated she was working evening shift on 5/9/11. She indicated her shift was almost over, and "[Resident A] had been up and down." She indicated Resident A was sitting in a wheelchair at the nurses desk, and LPN # 1 said, "Let's put her down on the floor." LPN # 3 indicated CNA # 3 at first just ignored her, but then LPN # 1 asked again, and she saw them put Resident A on the floor. LPN # 3 indicated someone got a mat and put it against the desk so Resident A could lean against the mat. LPN # 3 indicated, "Then [Resident A] just leaned down to the floor. She wasn't on a mat or anything. I don't think she even had a pillow. We were just shocked." LPN # 3 indicated her and LPN # 2 then left, and discussed the incident, and said, "This ain't right." LPN # 3 indicated that LPN # 1 was the 11-7 charge nurse, and they didn't want to question her. LPN # 3 indicated, "She was totally wrong, and we were wrong. We should have told someone." 2. On 7/11/11 at 10:40 A.M., the Director of Nursing provided the current facility policy on "Resident Safety Abuse Statement," revised 1/11. The policy			

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	included: "...Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being...Involuntary seclusion is defined as separation of a resident from other residents or from his/her room...Any suspected, observed or reported violation of this resident safety policy...will be reported to the supervisor and the DON and/or Administrator per facility policy immediately. b. the supervisor on duty shall IMMEDIATELY safeguard the resident(s) and report any alleged violations of this resident safety policy or observation...to the DON and/or Administrator or designee. The DON or designee will notify the Administrator if the are the first contact. c. The Administrator or designees shall determine if notification should be made to appropriate regulatory agencies (per state statute) or law enforcement agencies...." This Federal tag relates to Complaint IN00092333. 3.1-28(c)			

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F0226 SS=D	3-1-28(d) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure its policy was followed related to timely reporting of allegations of abuse to the Administrator and State agency, in that staff secluded Resident A and staff did not report the incident to the Administrator for 4 days, and the incident was not reported to the State agency for over 1 month, for 1 of 4 residents sampled for allegations of abuse, in a sample of 4. Resident A Findings include: 1. On 7/11/11 at 9:10 A.M., the Director of Nursing [DON] provided a "Fax/Incident Report" to the Indiana State Department of Health, dated 6/16/11. The report included, "An incident was reported to the Director of Nursing Services on 05/13/2011 at approximately 2:00 P.M. by [QMA # 1]. She reported that on the evening of May 9th, 2001 [sic], at approximately 10:30 P.M., [LPN # 1] instructed [CNA # 3] to assist her to remove [Resident A] from her wheelchair and place her on the floor behind the central nurses station. The area being described is open for all residents and	F0226	F 226The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents.The facility does not employ individuals who have been bound guilty of any form of mistreatment, nor does the facility employ any person with negative findings on the nurse aide registry.All staff training on the facility abuse prohibition and reporting policy was conducted on May 23 and July 25, 2011.LPN #1 was immediately suspended pending investigation and terminated for failure to follow established facility policy. LPN # 3 and all other staff present were counseled regarding facility policy and reporting requirements.There was no evident harm to Resident A. After subsequent review, the facility submitted a report summary to the State Department of Health. Facility policies and protocols have been reviewed and are consistent with current accepted standards of practice. The facility did conduct an immediate investigation and timely, appropriate action was taken including the immediate supension and termination of LPN #1.In accordance with facility policy and the law, the NHA of designee will report allegations	07/31/2011

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	staff to view. [QMA # 1] reports to DON that the first request from [LPN # 1] to [CNA # 3] was ignored. Upon second request from [LPN # 1] to [CNA # 3] at that time [CNA # 3] did assist her nurse in laying said resident on the carpeted floor behind the nurses work station. The DON phoned [CNA # 3] regarding this occurrence, at that time she confirmed that the incident actually did occur. She states exactly the same facts previously reported by [QMA # 1] and adds she did not feel good about the situation, however it only lasted for approximately 20-30 minutes, and then she placed said resident in her bed for slumber..As I am aware this reporting is thirty days past the actual incident of occurrence, through the QA [quality assurance] process the IDT [interdisciplinary team] felt it important to report this incident to prevent possible occurrence in an alternate long term care facility." On 7/11/11 at 10:35 A.M., during interview with LPN # 2, she indicated she was working evening shift on 5/9/11. LPN # 2 indicated Resident A "had dementia, and was in and out of bed." LPN # 2 indicated the evening staff had put Resident A in a wheelchair and had wheeled her to the nursing station at approximately 10:30 P.M. LPN # 2 indicated LPN # 1 was the oncoming		within the established time line as appropriate.The NHA will randomly question staff during daily rounds twice per week for six weeks and weekly for four months regarding staff knowledge of miscondut definitions and immediate reporting requirements. A recap of the facility safety policy and reporting guidelines will be provided to staff at monthly meetings for the following six months.The NHA will monitor for compliance and report any negative findings to the Quality Assurance committee.	

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	night shift nurse, and said "I'm not going to do this all night," and had her CNA put Resident A on the floor. LPN # 2 indicated she told LPN # 1, "You can't do that." LPN # 2 indicated her shift was over, and as her and the other evening shift nurse were walking out, they discussed that LPN # 1 "shouldn't have done that." LPN # 2 indicated, "We should have said something." On 7/11/11 at 12:05 P.M., during interview with QMA # 1, she indicated she was working evening shift on 5/9/11. She indicated, "[Resident A] sometimes won't lay still in bed. We sat her at the nurses desk. The other shift came in. I heard [LPN # 1] tell an aide 'Help me.' They were picking [Resident A] up and laying her on the floor. She was just sitting on the floor, and then laid over. I looked at [LPN # 3] who was my supervisor. Then I said, 'I'm out of here.'" QMA # 1 indicated this happened at approximately 10:30 P.M., at the end of her shift. QMA # 1 indicated she reported the incident to the DON 4 days later, because she "thought she would explode." QMA # 1 indicated the incident made her sick to her stomach. On 7/11/11 at 1:00 P.M., during interview with the DON, she indicated, "[QMA # 1] came into my office on a Friday			

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	afternoon, and was tearful. She said something happened the previous Monday at approximately 10:25-10:30 P.M. She said [LPN # 1] had come into work, and [Resident A] had been restless. [LPN # 1] told [CNA # 3] to 'come here and help me. We are just going to lay her down on the floor.' [CNA # 3] helped [LPN # 1] lay her on the floor." The DON indicated she immediately inserviced staff on abuse, gave written warnings, and terminated LPN # 1 after an investigation. On 7/11/11 at 1:20 P.M., during interview with LPN # 3, she indicated she was working evening shift on 5/9/11. She indicated her shift was almost over, and "[Resident A] had been up and down." She indicated Resident A was sitting in a wheelchair at the nurses desk, and LPN # 1 said, "Let's put her down on the floor." LPN # 3 indicated CNA # 3 at first just ignored her, but then LPN # 1 asked again, and she saw them put Resident A on the floor. LPN # 3 indicated someone got a mat and put it against the desk so Resident A could lean against the mat. LPN # 3 indicated, "Then [Resident A] just leaned down to the floor. She wasn't on a mat or anything. I don't think she even had a pillow. We were just shocked." LPN # 3 indicated her and LPN # 2 then left, and discussed the incident, and said, "This ain't right." LPN # 3 indicated that			

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	LPN # 1 was the 11-7 charge nurse, and they didn't want to question her. LPN # 3 indicated, "She was totally wrong, and we were wrong. We should have told someone." 2. On 7/11/11 at 10:40 A.M., the Director of Nursing provided the current facility policy on "Resident Safety Abuse Statement," revised 1/11. The policy included: "...Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being...Involuntary seclusion is defined as separation of a resident from other residents or from his/her room...Any suspected, observed or reported violation of this resident safety policy...will be reported to the supervisor and the DON and/or Administrator per facility policy immediately. b. the supervisor on duty shall IMMEDIATELY safeguard the resident(s) and report any alleged violations of this resident safety policy or observation...to the DON and/or Administrator or designee. The DON or designee will notify the Administrator if the are the first contact. c. The			

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	Administrator or designees shall determine if notification should be made to appropriate regulatory agencies (per state statute) or law enforcement agencies..."" This Federal tag relates to Complaint IN00092333. 3.1-28(a)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent Resident A from multiple falls, in that alarms were used in place of supervision, for 1 of 3 residents sampled for falls, in a sample of 4. Resident A Findings include: 1. On 7/11/11 at 9:25 A.M., Resident A was observed lying in a low bed in her room. On 7/11/11 at 9:30 A.M., the clinical record of Resident A was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and Parkinson's disease.	F0323	F323The facility does strive to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. Facility systems, policies and protocols have been reviewed and are appropriate.The MDS, care plan and fall history of Resident A will be reviewed and updated as necessary by August 11, 2011. The MDS nurse will ensure the nurse aide assignment sheets (care plan) contain appropriate content.The Director of Nursing shall review resident fall histories for the past four months. The MDS, care plans will be updated as necessary by August 11, 2011.The Administrator shall monitor for compliance by reviewing nursing notes, 24 hour	08/11/2011

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	An admission Minimum Data Set [MDS] assessment, dated 3/14/11, indicated the resident scored a 5 out of 15 on cognitive status, with 15 indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of two+ staff for transfer and toilet use, and did not ambulate. A test for "Balance During Transitions and Walking" indicated the resident was "not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, turning around, moving on and off of the toilet, and surface-to-surface transfer. The MDS assessment indicated Resident A had fallen since admission and received one injury. Nurses Notes included the following notations: 3/14/11 at 12:39 A.M.: "Incident Type: Observed on floor. Date of Incident: 3-13-11,Time of Incident: 10:35pm [sic]. Location: Resident's room. Resident's Condition Prior: Confused Normal for resident, Activity at the Time: Walking...Injury: Bruise: to LT [left] elbow, Abrasion: to LT shoulder...Immediate Intervention Implemented: Gripper socks/appropriate footwear - has regular socks on were		report sheets and nurse aide assignment sheets three times a week for eight weeks and weekly for six months. Negative findings will be reported to the Quality Assurance committee. If negative outcomes are reported i.e. incidents without immediate interventions, multiple incidents for one resident, the Administrator will continue to monitor until compliant with interventions and supervision. Incidents are reviewed monthly during the Quality Assurance meetings.The Director of Nursing will review all care plans and care plan updates for the next four weeks to ensure those at risk for falls have a care plan in place. The Director of Nursing shall review three per week for the next two months and report negative findings to the Quality Assurance committee.	

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	taken off...alarm placed in bed - which res [resident] attempted to get up on own x 3 since alarm put in bed thus far staff was able to get to res before res was walking aroun [sic] in room. Assessment Supporting Intervention: yes, alarm is helpful - it will cut down on some of the falls." 4/4/11 at 4:07 A.M.: "Incident Type: Observed on floor. Date of Incident: 04/04/2011,Time of Incident: 02:15AM [sic]. Location: Resident's room. Resident's Condition Prior: Normal for resident, Activity at the Time: Transferring self from bed without assistance...Injury: Bruise: to left side face at eye and cheek, First Aid:...Transferred to emergency room...Immediate Intervention Implemented: resident is receiving PT [physical therapy] 3 times a week/ambulates with staff/has alarms for bed and w/c [wheelchair] constance [sic] reminders are no help resident attempted 3 time [sic] to get out of w/c after fall. Assessment Supporting Intervention: Resident is monitored at all times without success." 4/8/11 at 9:45 P.M.: "Incident Type: Observed on floor. Date of Incident: 04/07/2011,Time of Incident: 10:45PM [sic]. Location: Resident's room. Resident's Condition Prior: Normal for			

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	resident, Activity at the Time: Sitting in recliner...Injury: No apparent injury...." 4/9/11 at 5:40 P.M.: "Incident Type: Observed on floor. Date of Incident: 04/09/2011,Time of Incident: 04:30PM [sic]. Location: Resident's room. Resident's Condition Prior: Normal for resident, Activity at the Time: Resident had been laying in bed...Immediate Intervention Implemented: resident already has bed and chair alarm and receives therapy. Assessment Supporting Intervention: [left blank]." 4/11/11 at 2:40 P.M.: "Incident Type: Observed on floor. CNA went into room when alarm sounded and resident [sic] was beside bed on knees stated she needed to go to bathroom. Location: Resident's room. Resident's Condition Prior: Oriented, Activity at the Time: Transferring...Immediate Intervention Implemented: Motion alarm mounted to bed frame. Date of incident: 04/11/2011, Time of incident: 09:16AM." 4/27/11 at 10:45 P.M.: "Incident Type: Observed on floor. Date of Incident: 04/26/2011,Time of Incident: 7:00PM. Location:...at the end of 200 hall in the selerium [sic]. Resident's Condition Prior: Normal for resident, Activity at the Time: In wheelchair...Immediate Intervention			

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	Implemented: [left blank]." 5/3/11 at 2:12 P.M.: "Incident Type: Observed on floor. Date of Incident: 05/03/2011,Time of Incident: 01:30PM. Location: Hallway. Resident's Condition Prior: Normal for resident, Activity at the Time: had stood up from wheelchair without assistance, alarm was sounding and staff responded at time of alarm sounding...Injury: Skin tear; on right side of back of head...Immediate Intervention Implemented: resident has chair alarm at all times, resident had been toileted at time of incident. Assessment supporting intervention: [left blank]." 5/8/11 at 1:56 P.M.: "Incident Type: Resident slid out of wheelchair. Date of Incident: 05/08/2011,Time of Incident: 01:45PM. Location: Nurses Station. Resident's Condition Prior: resident had fallen asleep in wheelchair, Activity at the Time: sitting in wheelchair...Immediate Intervention Implemented: [left blank]." 5/16/11 at 4:04 A.M.: "Incident Type: Resident rolled out of bed. Date of Incident: 05/16/2011,Time of Incident: 04:13AM. Location: Resident's room. Resident's Condition Prior: sleeping, Activity at the Time: resident stated she was rolling over and slid off side of bed...."			

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	5/18/11 at 8:11 A.M.: "Incident Type: Observed on floor. Date of Incident: 05/18/2011,Time of Incident: 07:29AM. Location: Hallway down 400 hall. Resident's Condition Prior: sleeping in chair, Normal for resident, Activity at the Time: sleeping in chair... Injury: Bruise: on middle of forehead right at hairline, purple size of golf ball size...CNA [name] ran to alarm sounding, nurse [name] was down hall...." 5/19/11 at 10:55 A.M.: "Incident Type: Observed on floor. Date of Incident: 05/19/2011,Time of Incident: 10:44AM. Location: Resident's room Resident's Condition Prior: Normal for resident, Activity at the Time: sleeping in bed...." 5/21/11 at 5:50 P.M.: "Incident Type: Witnessed fall. Date of Incident: 05/21/2011,Time of Incident: 12:15PM. Location: Dining room . Resident's Condition Prior: Normal for resident, Activity at the Time: resident was being taken into dining room for lunch by staff...Immediate Intervention Implemented: lap buddy is to be on at all times until transfer to straight back chair in dining room." 5/27/11 at 3:17 A.M.: "Incident Type: Observed on floor . Date of Incident:			

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	05/27/2011,Time of Incident: 2:15AM. Location: Resident's room . Resident's Condition Prior: Confused, Normal for resident, Dx [diagnosis] Alzheimers. Activity at the Time: Transferring - res was getting up for the day...Immediate Intervention Implemented: we have done all interventions poss with this res. d/t [due to] res's dx res does not use call light. had PT [physical therapy] et [and] OT [occupational therapy]. toileting q [every] 2 hrs. et more freq during freq fall x's which 1:00 am et 3:30 am thru the noc [night]. has bed alarm to alert staff res is attempting to transfer self. has special mattress et still res climbs out of bed when she wishes - we have tried everything within res's rights. res gets aggitated [sic] easily when unable to do what she wants when she wants majority of the x res wants to go home - unablr [sic] to redirect res. has lap budy [sic]...cont to the best of our ability to keep res safe - d/t res's dx res will fall again staff will get to res ASAP d/t sound of alarm since res does not use call light thru the noc." 6/8/11 at 3:52 P.M.: "Incident Type: Observed on floor . Date of Incident: 06/08/2011,Time of Incident: 2:45PM. Location: Resident's room . Resident's Condition Prior: Confused, Normal for resident. Activity at the Time: resident			

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	attempting to get out of recliner per self...Immediate Intervention Implemented: resident up in wheelchair, and given a snack per her request. stated she did not need to be toileted at that time. resident currently has a bed and chair alarm. Chair alarm was on and functioning at time of incident...." A Care Plan, dated 3/4/11 and updated 6/13/11, indicated a problem of "Potential for Trauma-Falls related to: Decline in cognitive status, Appliance or device used, Unsteady gait, Decline in functional status, Incontinence, Dementia manifested by History of falls, Use of psychotropics, Impaired sense of balance, Unsteady gait." The approaches included: "...Encourage to ask for assistance..., Monitor closely..., Call light in reach...3-7-11 Begin toileting plan...3-14-11 Bed alarm applied...3-20-11 Chair alarm to alert staff. 4-11 Increase Xanax [anti-anxiety medication] R/T [related to] restlessness...low bed/wt sensitive chair alarm, position/tilt w/c [wheelchair] to help keep resident torso in position." On 7/11/11 at 11:10 A.M., Resident A was observed sitting in a wheelchair in the activity room. She appeared to be asleep. An activity was taking place at a large table, with two activity staff assisting residents. Resident A was not seated at the			

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	table, but was away from the activity facing a television. On 7/11/11 at 11:45 A.M., Resident A was observed sitting in the activity room. No staff were present. A staff member was observed to be wheeling residents to the dining room. On 7/11/11 at 1:00 P.M., during interview with the Director of Nursing, she indicated Resident A had a cervical curvature, and "could just fall right out of her chair." On 7/11/11 at 2:00 P.M., during interview with the Administrator, she indicated the resident had not fallen since June, when they obtained the "new chair." 2. On 7/12/11 at 9:45 A.M., the Director of Nursing provided the current facility policy on "Fall Assessment & Prevention Protocol," revised 6/11. The policy included: "Purpose: To ensure the appropriate actions are taken to assess, prevent and reduce resident falls...Update the resident care plan with the appropriate intervention(s) to keep resident safe...Any trends or patterns in falls will be evaluated through the facility Quality Assurance process on a monthly/quarterly basis...." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155632	A. BUILDING 00 B. WING	07/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LODGE OF THE WABASH	723 E RAMSEY RD VINCENNES, IN47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE